DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

2. STATE:

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252 and 42 CFR 413

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 133 million
b. FFY 2005 $ 144 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D Section IV pages 12-20, 20a, ~~20b~~ 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19 -D, Section IV pages 12-19, 19a, 20, ~~+~~25

10. SUBJECT OF AMENDMENT:

nursing facilities: definition clarifications; rate relief criteria; and, continuation of quality programs

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Paul Reinhart, Deputy Director for Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Paul Reinhart

14. TITLE:
Deputy Director

15. DATE SUBMITTED:
December 7, 2003

16. RETURN TO:
Medical Services Administration
Program Policy - Federal Liaison Unit
400 South Pine - 7th Floor
Lansing, Michigan 48933
ATTN: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
NOV 10 2003

18. DATE APPROVED:
JUN 14 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Brown for Smith

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:
Pen + ink change to block # 8, remove 20b

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Policy and Methods for Establishing Payment Rates
(Long Term Care Facilities)

B. Plant Cost Component (for Class III facilities and grandfathered Class I and Class II facilities)

4. Special Provisions (continued)

c. New Facility: A "new facility" is defined as a LTC provider in a facility that does not have a Medicaid historical cost basis. The new provider's initial-period plant cost component will be the provider's certified and agency approved plant cost per patient day (per Section IV.B.4.a.) up to the plant cost limit, where the plant cost limit is determined using update methods 1) and 2) of Section IV.B.4.b. above.

d. Additions, Renovations and Newly Constructed Facilities: The provider's initial plant cost component subsequent to the changes in plant costs will be the provider's certified and agency approved plant cost per patient day (per Section IV.B.4.a.) up to the plant cost limit, where the plant cost limit is the weighted average (using proportions of historical cost) of the historic PCL for the portion of the facility that remains unchanged, and the PCL applicable to the new portion, determined using update methods 1) and 2) of Section IV.B.4.b. above.

e. Sales and Resales: Sales and resales will be recognized by the program. Reimbursement for providers with facilities purchased prior to July 18, 1984, will be determined in accordance with the State Plan methods applicable at the time of sale. Reimbursement for providers with facilities purchased on or after July 18, 1984, but not the result of a binding agreement entered into prior to July 18, 1984, will use as a plant cost basis, allowable cost as determined in accordance with the Medicare Principles of Reimbursement as modified in Section III. In all cases of sale or resale, the seller must notify the State agency at least 90 days in advance of purchase. The sale will not be recognized for reimbursement purposes until 90 days after notification. Provisions of 42 CFR 413.134 (f) will be retrospectively satisfied at this time. Any exception must be approved by the State agency. In the event of sale there will be an application of 45 CFR 413.134 (f) for any reimbursement received by the seller as depreciation expense from October 1, 1984 through the effective date of the sale and the transfer of assets.

The provider's plant cost component subsequent to the sale will be the provider's certified and agency approved plant cost per patient day (per Section IV.B.4.a.) up to the plant cost limit determined using update method 2) of Section IV.B.4.b. above (only the interest portion of the limit is updated).

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B. Plant Cost Component (for Class III facilities and grandfathered Class I and Class II facilities)

4. Special Provisions (continued)

f. Change of Class: An existing provider becoming a Class III facility will be paid a plant cost component determined using the principles stated in Section IV.B.1. and IV.B.2. of this plan.

C. Variable Cost Component

For Class II provider cost reporting periods, beginning on or after January 1, 1989, the variable cost component of the prospective rate will be based on a submitted cost report. Cost will be settled retrospectively against a fixed ceiling using allowable cost principles, as defined in Section III of this attachment. Fixed variable component ceilings will be determined for each facility based on the submitted budget.

For provider cost reporting periods beginning on or after April 1, 1986, the variable cost component for long term care facilities in Classes I and III will be determined in accordance with the following sections. Rate setting for prior periods will be made in accordance with the State Plan in effect at the beginning of the provider's rate setting period.

1. Variable costs are defined as total allowable costs allocated to base and support costs in the routine service centers. Allowable costs and expenses are determined allowable in accordance with Medicare Principles of Reimbursement as modified by Section III of this attachment. The agency's cost reporting forms specifically allocate routine service center costs into base, support, and plant costs. Costs of other services are also allocated on the cost reporting forms into ancillary service centers (retrospectively cost settled or paid fee-for-service), home for the aged service centers, and other nonreimbursable service centers.

2. The variable cost component consists of two subcomponents – the base cost component and the support cost component. Base costs are generally defined as those costs which cover activities associated with direct patient care. Special add-ons to provide cash flow for anticipated costs that are not included in the cost base period may also be included in the rate. Effective for cost reporting periods beginning on or after October 1, 1990, base costs include: 1) labor costs and related benefits and payroll taxes except medical records, medical director, general and administration, housekeeping, and operation of plant cost categories; 2) raw and processed food costs; 3) the cost of all utilities; 4) consultant costs for base cost categories from a related organization; 5) the cost of contracted agency nursing personnel; 6) linen; 7) all worker compensation costs; and, 8) all other costs incurred in base cost categories except as specifically defined as support costs.

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C. Variable Cost Component

2. (continued) Effective for cost reporting periods beginning on or after October 1, 1990, support costs are considered to be all other variable costs, including administrative costs; consultant costs regardless of the department with which the cost is associated; all equipment repair and maintenance costs; and all materials and supplies except for those included in base costs. More specifically:

   a. Base costs are defined as allowable costs (i.e., with related organization profit removed) for:

      1) Payroll related costs (salaries, wages, related payroll taxes and fringe benefits) for core departments of nursing, dietary, activities, social services and laundry plus these other major cost item: raw and processed food; linen (does not include mattresses or springs); workers' compensation; utility costs; consultant costs for base cost categories from related organizations; and supply costs incurred in all base cost departments.

      2) Purchased services and contract labor from unrelated parties or from related organizations, except for nursing services, incurred in lieu of base costs as defined in Section 1, immediately above, are separated into base and support costs using the industry-wide average base-to-variable-cost ratio. The industry-wide average base-to-variable-cost ratio will be reviewed at least annually and revised when a change of 2% or greater occurs. The ratio will be based on cost reports filed in the calendar year that is two years prior to the end of the current fiscal year. The purchased services to be allocated using this method are exclusively limited to contracted services for costs incurred in base cost categories. All other purchased services are defined as support costs.

   b. Support costs are defined as:

      The payroll related costs of the departments of housekeeping and maintenance of plant operations; administrative costs; all consultant costs, all equipment maintenance and repair costs; and all other allowable variable costs, purchased services and contract labor not specified as base costs (i.e., variable costs minus base costs).

   c. The allowability of costs shall be determined in accordance with Medicare Principles of Reimbursement as modified in Section III above.

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C. Variable Cost Component (continued)

3. The rate determination methods using base and support costs to obtain the variable cost component are described below:

   a. A provider's indexed base cost component is determined as per patient day base costs taken from the provider's cost report ending in the previous calendar year indexed to October 1 of the year that is one year prior to the rate year being calculated. The base cost component will be rebased (recalculated) annually to reflect the more current costs of both the resource needs of patients and the business expenses associated with nursing care. The basis for the cost index is the Global Insight Health Care Cost Review, DRI-WEFA Skilled Nursing Facility Market Basket without Capital Care Cost Review.

      1. Beginning October 1, 2003, the annual economic inflationary rate for Class I and Class III facilities is 0%.

      2. The State will conduct annual studies relating actual industry costs to the inflationary adjusters used in setting prospective rates, within the context of the total rate. MSA will share the study results at the next Long Term Care Liaison meeting following completion of the study.

         If more than 20 percent of facilities in a class identify and document that new State or Federal requirements are anticipated to add more than 1 percent to the classwide average rates of facilities, the State will convene a work group that includes provider representatives to discuss and recommend adjustments to the prospective reimbursement system to meet those new costs. The state agency will act upon these recommendations within 90 days of their receipt. This provision does not apply to minimum wage changes April 1, 1991.

   b. A provider's indexed support cost component is determined as the provider's indexed base cost component times the lesser of the provider's support-to-base (S/B) ratio or the support-to-base ratio for that facility's bed size group.
   For Class I and Class III facilities rate periods beginning on or after October 1, 2003:

      1) The provider's S/B ratio is determined from the cost report ending in the previous calendar year, indexed to October 1 of the year that is one year prior to the rate year being calculated.

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C. Variable Cost Component

3. The rate determination methods using base and support costs to obtain the variable cost component

b. A provider's indexed support cost component is determined (continued)

2) The provider's S/B ratio is limited to the 80th percentile S/B ratio for the provider's bed size group. The bed size groups shall be 0-50, 51-100, 101-150 and 151+ licensed nursing beds in the facility or nursing complex.

3) The provider's S/B ratio is rebased annually regardless of ownership.

4) An individual facility's support limit will be computed by multiplying the applicable annual ratio limit for the provider's facility size grouping times the provider's per patient day base cost for the period. If a provider's support component exceeds the limit, the provider will be paid the limit amount, which is based on the appropriate bed size grouping.

5) The 80th percentile support-to-base ratio limits will be determined annually from the cost reports ending in the previous calendar year for each size grouping. The 80th percentile support-to-base ratio limit will be determined in a like manner as the variable cost limit described in Section IV C.3.c.2 of this plan.

c. The provider's variable rate base is determined as the lesser of the variable rate base or the provider's classwide variable cost limit (VCL), where:

1) The classwide VCL is set at the 80th percentile of the indexed variable costs for nursing care facilities in the class during the calendar year.

2) To determine the classwide VCL, the State first rank orders providers from the lowest to the highest indexed Medicaid per patient day variable cost. The 80th percentile is then identified by accumulating Medicaid patient days of the rank ordered providers from the lowest indexed per patient day variable cost provider until 80 percent of the total Medicaid days for this class is reached. The indexed Medicaid per patient day variable cost of the facility in which the last patient day was accumulated is the variable cost limit for the class of providers.

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C. Variable Cost Component (continued)

3. The rate determination methods using base and support costs

c. The provider's variable rate base is determined as the lesser of the variable rate base or the provider's classwide variable cost limit (VCL), where (continued):

3) The variable cost limit for private institutions for the mentally ill and mentally retarded is computed by adding the VCL for Class I nursing facilities plus the cost of additional nursing hours per patient care day plus the cost of additional services as required by the Department, as outlined in the Supplement to Attachment 3.1-A.

4. Nursing Facility Class I Rate Relief

a. Criteria for Eligibility for NF Class I Rate Relief – A Class I nursing facility provider may apply for rate relief from the usual rate setting process if they meet the following eligibility criteria:

1) The provider must demonstrate that the current Medicaid rate does not provide them with adequate funding to deliver the level of care to the Medicaid beneficiaries in the facility such that "each resident attains and maintains the highest practicable physical, mental and psycho-social well-being" as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987.

2) The nursing facility Variable Rate Base amount meets the following criteria:

a) For a current provider – The facility's Variable Rate Base is at or below the corresponding class Average Variable Cost. The class Average Variable Cost used for this determination is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested; or,

b) For a new provider in a Medicaid-enrolled nursing facility – The facility's current Variable Rate Base is at or less than 80 percent

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C. Variable Cost Component

4. Nursing Facility Class I Rate Relief

a. Criteria for Eligibility

2) b) continued

of the corresponding class Average Variable Cost. The class Average Variable Cost used for this determination is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested. (A new facility with a Variable Rate Base between 80 and 100% of the corresponding class Average Variable Cost will be eligible for accelerated rebasing and will be treated as a current provider)

3) A current Medicaid provider agreement for the facility is in effect, except when applying under criteria 4) e). The rate relief period will be based on the facility, and not the owner, provider, or licensee. A change of ownership, provider, or licensee during the rate relief period would not end the agreement for rate relief under this policy, so long as the new owner, provider, or licensee fully complies with the requirements of the rate relief agreement.

4) The provider must also meet at least one of the following five criteria:

a) The sum of the provider's Variable Rate Base, Economic Inflation Update and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the net Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per patient day for the two years prior to the first year of rate relief. Costs for Nurse Aide Training and Testing are not included in the Medicaid variable costs. To demonstrate this difference, the provider must submit an analysis comparing their variable costs incurred and variable costs reimbursed for the two years previous to the year for which rate relief is requested.

b) The provider is required, as a result of a survey by the state or federal regulatory agency, to correct one or more substandard quality of care deficiency to attain or sustain compliance with Medicaid certification requirements. The survey must have occurred within six months prior to the provider's request for rate relief. The provider must submit a copy of

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C. Variable Cost Component

4. Nursing Facility Class I Rate Relief

a. Criteria for Eligibility

4) b) continued

the citation and an approved Plan of Correction outlining the action being taken by the provider to address the requirement(s); or

c) The facility has a significant change in the level of care needed for current Medicaid residents. A significant charge is defined as an increase of at least 10 minutes of nursing care per resident per day. The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. The Minimum Data Set (MDS) data must be used for this comparison. This data will be subject to a clinical review by DCH clinical staff. The analysis must also include a comparison of the previous and current nursing staffing levels required and other nursing related costs or requirements likely to increase the operational costs; or

d) The provider is new in a Medicaid Enrolled facility and the facility's most recent cost report submitted to DCH was incomplete, undocumented or had unsubstantiated cost data by the previous provider. Inadequate cost reporting would include non-payment of accrued liabilities due to the previous provider's bankruptcy as determined by Medicaid auditors in accord with Medicaid allowable costs, or inadequate records to support the filed cost report. Proof of the change of ownership must be submitted along with an explanation of why the cost report data is inadequate to calculate the provider's reimbursement rate; or,

e) Rate relief is needed because the facility will be closed due to a regulatory action by the state or federal regulatory agency where the facility's closure will result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider will operate the facility at it's current reimbursement rate. A facility would meet this hardship criteria if it is the only nursing facility in the county or, the closing facility has at least sixty-five percent of the Medicaid certified beds in that county.

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C. Variable Cost Component

5. Special Provisions:

a. New Facility (continued):

facility that does not have a Medicaid historical cost basis, will be paid in accordance with Section c. below.

b. Change of Class: An existing enrolled nursing facility which becomes a Class I or III facility, will be paid in accordance with Section c. below.

c. Payment Determination:

1) During the first two cost reporting periods, rates for providers defined in Sections a. and b. above will be calculated using a variable rate base equal to the class average of variable costs.
2) In subsequent periods the provider's variable rate base will be determined using methods in Section IV.C.1. through IV.C.3. above.

6. Beginning October 1, 2003, Class I, and non-publicly owned Class III nursing facilities will receive a monthly payment as part of a Quality assurance Assessment Program (QAAP). A facility's QAAP payment will be based on the facility's Medicaid utilization multiplied by a Quality Assurance Supplement (QAS). A facility's Medicaid utilization will be the sum of all routine nursing care and therapeutic leave days billed to Medicaid by that facility during a 12-month period beginning in June of the previous calendar year. The per diem rates for nursing facility bed days where Medicaid pays room and board for hospice residents in nursing facilities will be increased to include the QAAP. Hospice will be responsible for reimbursing nursing facilities for room and board consistent with their contract. The QAS is equal to 21.76% of the lesser of the facility's variable rate base or the class variable cost limit. The nursing facility's current fiscal year rate is based on the facility's cost report for the second fiscal year prior to the current fiscal year. For the current fiscal year, this QAS payment will result in a gross increase of approximately 11.5% over the prior fiscal year's nursing facility rate in aggregate.

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G. Payment Determination for Special LTC Facilities

The payment rates for all special facilities for ventilator-dependent patients shall be a flat per patient day prospective rate determined by the single State agency. The special LTC facility prospective rate shall not be subject to the provisions in Sections IV.A. through IV.F. above, but instead the provisions within this section shall be used for payment determination.

1. Payment shall be made for prior authorized ventilator-dependent patients who have been transferred from an acute care inpatient hospital setting to a qualifying special LTC facility. The prospective rate shall cover care requirements of the patients, including all the costs of benefits associated with Medicare Parts A and B services while the patient resides in the special LTC facility. This includes but is not limited to all routine, ancillary, physician and other services related to ventilator care.

   The purpose of the special rate is to provide the facility with payments meant to cover the cost of necessary physician's services including services in the capacity of a case manager who will prescribe and monitor, on a case-by-case basis, habilitative and rehabilitative services necessary for management of the ventilator dependency. The ultimate goal is de-institutionalization of those ventilator-dependent patients who may gain an adequate level of independence.

2. Factors used by the single State agency in the determination of the per patient day prospective rate shall include audited costs at facilities providing similar services expected increases in the appropriate inflationary adjustor over the effective period of the prospective rate, the supply response of providers and the number of patients for whom beds are demanded. The prospective rate will not exceed 85 percent nor fall below 15 percent of an estimate of the average inpatient hospital rate for currently placed acute-care Medicaid patients who are ventilator dependent. The prospective rate shall be periodically re-evaluated (no more than annually) to ensure the reasonableness of the rate and the appropriate balance of supply and demand for special care is met.

3. The cost basis shall be determined in accordance with Section I through III of this plan, excluding Sections III.B., III.C. and III.D. Providers are required to maintain distinct part accounting records for all costs associated with the special LTC beds to ensure those costs are not included as a reimbursement basis in the other distinct parts of the facility.

4. Beginning October 1, 2003, non-publicly owned ventilator-dependent care units licensed as nursing facilities will receive a monthly payment as part of a Quality Assurance Assessment Program (QAAP). A facility's QAAP payment will be based on the facility's Medicaid utilization multiplied by a Quality Assurance Supplement (QAS).). A facility's Medicaid utilization will be the sum of all routine nursing care and therapeutic leave days billed to Medicaid by that facility during a 12-month period beginning in June of the previous calendar year. The QAS is equal to 21.76% of the Class I variable cost limit.